DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 2 — 0 9

2. STATE: Missouri

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
January 1, 2002

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.257, 447.272 and 447.304

7. FEDERAL BUDGET IMPACT:
a. FFY 2002 $ 10 million
b. FFY 2003 $ 10 million

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19D Pages 224 and 229
Missouri (02-09)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19D Pages 224 and 229
approved: 12/11/02
effective: 01/01/02

10. SUBJECT OF AMENDMENT:
Allows payment to State Owned and Operated Intermediate Care Facilities for the Mentally Retarded up to what would have been paid to those facilities under Medicare principles.

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT cc
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Christine Kackers for

13. TYPED NAME:
for Dana Katherine Martin

14. TITLE:
Director

15. DATE SUBMITTED:
3/28/02

16. RETURN TO:

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
03/29/02

18. DATE APPROVED:
DEC 11 2002

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
01/01/02

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Thomas W. Lenz

22. TITLE:
ARA for Medicaid and State Operations

23. REMARKS:
cc:
Martin
Vadner
Waite
CO
DSG/DIATA

SPA CONTROL

Date Submitted: 03/28/02
Date Received: 03/29/02

FORM HCFA-179 (07-92)

Instructions on Back

Retrospective Reimbursement Plan for State-Operated Facilities for ICF/MR Services

(1) Objectives. The retrospective rate plan described in this rule shall apply to state-operated intermediate care facility/mentally retarded (ICF/MR) facilities for dates of service on and after March 1, 1990, and the objective of this plan is to provide reimbursement of allowable cost.

(2) General Principles. The Missouri Medical Assistance program shall reimburse qualified providers of ICF/MR services based solely on the individual Medicaid recipient's days of care (within benefit limitations) multiplied by the facility's Title XIX per-diem rate and the payment from the supplemental enhancement payment pool as described in (5)[1] less any payments made by recipients as described in sections (4) and (5).

(3) Definitions.

(A) Allowable cost areas. Those cost areas which are allowable for allocation to the Medicaid program based upon the principles established in this plan. The allowability of cost areas not specifically addressed in this plan will be based upon criteria of the Medicare Provider Reimbursement Manual (HIM-15) and section (7) of this rule.

(B) Cost report. The cost report shall detail the cost of rendering covered services for the fiscal reporting period. Providers must file the cost report on forms provided by and in accordance with the procedures of the department.

(C) Department. The department, unless otherwise specified, refers to the Missouri Department of Social Services.

(D) Director. The director, unless otherwise specified, refers to the director, Missouri Department of Social Services.

(E) Division. The division, unless otherwise specified, refers to the Division of Medical Services.

(B) When information contained in a facility's cost report is found to be fraudulent, misrepresented or inaccurate, the facility's final rate at the discretion of the division may be both retroactively and prospectively adjusted if the fraudulent, misrepresented or inaccurate information as originally reported resulted in establishment of a different final rate than the facility would have received in the absence of that information.

(5)[1] Supplemental Enhancement Payment Pool. Each state-owned and operated facility for the mentally retarded (ICF/MR) will be paid an annual supplement, payable in quarterly installments, to increase aggregate reimbursements to state-owned and operated ICFs/MR to the amount that the state reasonably estimates would have been paid under Medicare Payment Principles. The determination will be in conformance with the standards and methods as expressed in 42 C.F.R. 447.257, 447.272, and 447.304.

The estimate of the amount that would be paid under Medicare payment principles ("the Medicare UPL") is based on the following methodology. Utilizing cost and utilization data from state-owned and operated ICF/MR facility desk-audited cost reports for state fiscal year 2001 ("the Medicare UPL base year"), compute 112% of the weighted mean cost per patient day ("the 112% amount"). The weighted mean cost per day will be trended forward to state fiscal year 2003 by applying a rate of change equal to the CMS Skilled Nursing Facility Input Price Index (Four Quarter Moving Average). The result is the estimated Medicare reimbursement cost per day for state fiscal year 2003. Calculations for future fiscal years will be determined by trending the weighted mean cost per day forward by the CMS Skilled Nursing Facility Input Price Index. This process will remain in effect for each state fiscal year until the designation of a new base year.

To determine the Medicare UPL for each state fiscal year beginning with state fiscal year 2002, take the trended cost per day multiplied by the estimated Medicaid patient days for the current fiscal year. The current fiscal year patient days are based on the Medicaid days of service provided in the immediately preceding fiscal year. A new Medicare UPL base year will be designated before the end of state fiscal year 2008.

The dollar amount used to calculate the difference between the Medicare UPL and the regular Medicaid per diem rate for each year is based on each year's state-owned and operated ICF/MR interim rate multiplied by the current year's number of Medicaid patient days. The result is subtracted from the Medicare UPL, which yields the final supplemental enhancement payment pool amount payable for the year. The supplemental enhancement payment pool is divided by the number of state-owned and operated ICF/MR facilities to determine the annual supplemental payment amount for each facility.

For each state fiscal year, the Medicare UPL calculated as described above is subject to increase to take into account any costs that state-owned and operated ICF/MR facilities are required to incur to comply with legal requirements that were not in effect during the Medicare UPL base year. The increase will be equal to the average per diem cost of complying with any such legal requirements times the total number of Medicaid patient days in the Medicare UPL current year.

(6) Covered Services and Supplies. ICF/MR services and supplies covered by the per-diem reimbursement rate under this rule, and which must be provided, are found in 42 CFR 442.100-442.516 and include, among other services, the regular room, dietary and nursing services or any other services that are required for standards of participation or certification, also included are minor medical and surgical supplies and the use of equipment and facilities. These items include, but are not limited to, the following:

(A) All general nursing services including, but not limited to, administration of oxygen and related medications, hand-feeding, incontinency care, tray service and enemas;

(B) Items which are furnished routinely and relatively uniformly to all recipients, for example, gowns, water pitchers, soap, basins and bed pans;

(C) Items such as alcohol, applicators, cotton balls, bandaids and tongue depressors;

(D) All nonlegend antacids, nonlegend laxatives, nonlegend stool softeners and nonlegend vitamins. All nonlegend drugs in one (1) of these four (4) categories must be provided to residents as needed and no additional charge may be made to any party for any of these drugs. Facilities may not elect which nonlegend drugs in any of the four (4) categories to supply; all must be provided as needed within the existing per-diem rate;

(E) Items which are utilized by individual recipients but which are reusable and expected to be available such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment and other durable, nondepreciable medical equipment;